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Guidelines

2017 ESC focused update on dual antiplatelet therapy in coronary artery disease developed in collaboration with EACTS[☆]

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1. Preamble

Guidelines and Focused Updates written under the auspices of the [European Society of Cardiology's](#) (ESC) Committee for Practice Guidelines (CPG) summarize and evaluate available evidence with the aim of assisting health professionals in selecting the best management strategies for an individual patient with a given condition ([Tables 1 and 2](#)).

2. Introduction

After 21 years of research, dual antiplatelet therapy (DAPT) has moved from a local (i.e. stent-related) to a systemic treatment strategy (i.e. capable of preventing thrombotic arterial vessel occlusion), conveying global patient protection ([Fig. 1](#)).

3. Efficacy and safety of dual antiplatelet therapy and risk stratification tools

3.1. Risk stratification tools for ischaemia and bleeding risks

Given the trade-off between ischaemic vs. bleeding risks for any given DAPT duration, the use of scores might prove useful to tailor DAPT duration in order to maximize ischaemic protection and minimize bleeding risks in the individual patient. The use of risk scores that were specifically designed to guide and inform decision making on DAPT duration should be prioritized over other available risk scores ([Table 3](#)).

Use of risk scores as guidance for the duration of dual antiplatelet therapy.

Recommendation	Class ^a	Level ^b
The use of risk scores designed to evaluate the benefits and risks of different DAPT durations ^c may be considered.	I b	A

DAPT = dual antiplatelet therapy.

^a Class of recommendation.

^b Level of evidence.

^c The DAPT and PRECISE-DAPT scores are those currently fulfilling these requirements.

3.2. Type of P2Y₁₂ inhibitor and timing of initiation

Recommendations on P2Y₁₂ inhibitor selection and timing.

Recommendations	Class ^a	Level ^b
In patients with ACS, ticagrelor (180 mg loading dose, 90 mg twice daily) on top of aspirin ^c is recommended, regardless of initial treatment strategy, including patients pre-treated with clopidogrel (which should be discontinued when ticagrelor is commenced) unless there are contraindications.	I	B
In patients with ACS undergoing PCI, prasugrel (60 mg loading dose, 10 mg daily dose) on top of aspirin is recommended for P2Y ₁₂ inhibitor-naïve patients with NSTEMI-ACS or initially conservatively managed STEMI if indication for PCI is established, or in STEMI patients undergoing immediate coronary catheterization ^c unless there is a high risk of life-threatening bleeding or other contraindications.	I	B
Pre-treatment with a P2Y ₁₂ inhibitor is generally recommended in patients in whom coronary anatomy is known and the decision to proceed to PCI is made as well as in patients with STEMI.	I	A
In patients with NSTEMI-ACS undergoing invasive management, ticagrelor administration (180 mg loading dose, 90 mg twice daily), or clopidogrel (600 mg loading dose, 75 mg daily dose) if ticagrelor is not an option, should be considered as soon as the diagnosis is established.	IIa	C
In patients with stable CAD, pre-treatment with clopidogrel may be considered if the probability of PCI is high.	IIb	C
Clopidogrel (600 mg loading dose, 75 mg daily dose) on top of aspirin is recommended in stable CAD patients undergoing coronary stent implantation and in ACS patients who cannot receive ticagrelor or prasugrel, including those with prior intracranial bleeding or indication for OAC.	I	A

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